

Blood-Stream Infection (CDC)

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To: Blood-Stream Infection (CDC)
Subject: Public Comments Fed Register

Line 1608

The references for this Recommendation are from 1998. The more recent references that many clinician are currently using need to be addressed in this 2009 revision.

The “preferred” statement is not substantiated with any references in this draft. The 2008 SHEA/IDSA Practice Guidelines recommend alcohol **or** chlorhexidine/alcohol which is the most supported statement at this point in time. (Kaler/Chinn , JAVA Fall 2007 12(3) 140)

The Category I should apply to the need to clean the port but the “Chlorhexidine preferred” is not a Category I as there are not well-designed studies to support it as being superior to alcohol. Chlorhexidine product is more costly to hospitals than alcohol. In addition, there are no long-term studies to determine the risk of residual chlorhexidine that is flushed into the patient’s bloodstream after it has been placed on the ports. Will this lead to development of serious allergic reactions? There are reports of skin sensitivity in a percentage of patients who are prepped with it prior to line insertion and surgical procedures.

Clear direction on the amount of time to disinfect the port has been omitted. Unfortunately, repeated observation of nursing practice has revealed that many nurses do not do more than one swipe with alcohol. In anonymous surveys, we have received responses ranging from “no time” to “30 seconds” as the time that nurses actually disinfect ports in actual practice.

The Menyhay /Maki study revealed that 5 seconds was not enough time to kill *enterococcus* that was impregnated on the valve.(Menyhay/Maki Study ICHE 2006 27:23)

Numerous clinicians have contacted me since the publication of the Kaler study and stated that they were appreciative of this practical study that provides evidence of how much time and technique (friction) is needed to adequately disinfect ports. AVA and INS have supported use of these practices for their members and clinicians nationwide have told me that they have put these procedures into practice.

Line 1612

There have been many reports of CRBSI since mechanical valves were put into use. However, in most of the reports there is no accounting for how the valves were actually disinfected prior to being accessed. If the proper disinfection process was used, the design of the valve does not determine if a CRBSI will occur. Kaler studied four different valves and all were able to be successfully disinfected. (Kaler/Chinn , JAVA Fall 2007 12(3) 140. If split septums are not disinfected properly CRBSI will continue to occur.

In practice, in the past three hospitals where I have worked we have used a Smartsite, Smartsite plus, and CLC200 and we have been able to decrease our CRBSI to meet our goals (without switching to a split septum) by focusing on proper cleansing of the port.

➤ I believe the best approach to this would be:

Line 1611 the same statement that is used to preface the recommendation for a CHG impregnated sponge “If after successful implementation of a comprehensive strategy utilizing processes to reduce CRBSI that the CRBSI remains above the goal’ consider using split septum ports.”

Line 1482

I have reviewed the literature regarding securement devices in an attempt to make a recommendation in my hospital to move away from sutures. I am looking for evidence that sutures are associated with higher CRBSI rates and have not found clinical studies to support this.

I could find only three studies that addressed the issue. Only one of these studies showed a decrease in infection in PICCs using securement devices. Is that enough evidence for a **Category II** recommendation or should this be ***Unresolved*** as per SHEA/IDSA Oct 2008?

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Thank You,

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